

New Jersey Department of Human Services  
Division of Aging Services  
PACE Administration  
PO Box 807  
Trenton, NJ 08625-0807  
609-588-7747

**PACE REQUEST FOR DEEMING OF CONTINUED ELIGIBILITY  
FOR NURSING FACILITY LEVEL OF CARE**

To request that a participant be deemed to have continued eligibility for Nursing Facility Level of Care, complete the information below and attach all required documentation listed on the form and submit to DHS, Division of Aging Services (DoAS) **45 days prior to the due date for annual recertification.**

Date: \_\_\_\_\_ Recertification Due Date: \_\_\_\_\_

Last NF LOC Assessment Date: \_\_\_\_\_

Name of Participant: \_\_\_\_\_

From (Name/Title): \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DoAS will initiate review of the request when **all of the following documentation has been received.** Omitting any information requested below may delay approval and jeopardize a participant's eligibility for continued enrollment in PACE.

- ☐ Justification summary from IDT
- ☐ Initial and most recent LOC assessment
- ☐ Diagnosis of chronic or disabling condition
- ☐ Last comprehensive assessment by all relevant disciplines
- ☐ Last 2 IDT care plans
- ☐ History and Physical
- ☐ Physician and nursing progress notes
- ☐ All specialty consultant notes (any discipline)
- ☐ Social work notes
- ☐ Diagnostic tests supporting request
- ☐ Medication and treatment record
- ☐ Other relevant documentation supporting the request

Above request is:

☐ Approved/Date: \_\_\_\_\_ ☐ Denied/Date: \_\_\_\_\_

Name and Title of Reviewer: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Telephone: \_\_\_\_\_